# Public Health targeting processes in Europe

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*"Who defines health strategies and what is their underlying logic?"*

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Since the 1970s, industrialised countries have implemented a number of different health system reforms in order to try and halt the inexorable increase in health care costs. This has lead to the strengthening of constraints on funding and the introduction of mechanisms similar to those found in the market.

Despite these reforms, costs continue to increase, but without a similar rise in both accessibility and quality. Trapped between the search for equity on one hand and the search for economic efficiency on the other, many countries have reached a stalemate in the political decision-making process. Having tried first to control costs, some European countries have slowly moved to implement a different approach to health care policy based on a system of setting health priorities and targets.

These priorities and targets are associated with three trends: the first is a necessary expansion in what is considered to be a health issue so that this is not only confined to the health care system, but to the broader range of factors that act as determinants of health. The second is the necessary integration of service users and citizens into the policy decision-making process. The third is the need to define common programmes for all stakeholders, not just health professionals, across the entire health care system.

Within this context, this article will demonstrate that governments determine health policy objectives in different ways. This is in terms not only of their nature and impact but also in terms of the respective responsibilities of different stakeholders, making decisions relative to the funding and implementation of strategic choices in health policy. Two major questions constitute the basis of this work: Who defines health strategies and what is the underlying logic of these strategies?

In order to respond to these questions, a three step process has been adopted. Initially literature on objective concepts, priorities, and health strategies, as well as national public health plans were collected and analysed. From this analysis scientific and policy experts were interviewed in England, Finland, Spain and Sweden. A questionnaire was subsequently sent to health system representatives in all 15 old EU countries in order to complete and validate information.

In the first section objectives and priorities are defined. The description of these systems allows us to analyse current trends in the decentralisation of decision-making processes. Then the processes at work are shown, as well as the points of convergence and divergence between the different countries studied.

## Health policy: a combination of curative and preventive approaches

Both countries operating through a federal or decentralised system develop their health policy on both health care and health promotion taking account of research findings on national cohesion, common purpose, and transparency. Because the principles by which their political structures have developed differ, disparities across these countries are strong in terms of social, economic and political matters, including access to health services. Thus, the issue of inequalities in health is an overriding objective that helps to define their health policies. In countries where independent institutions are responsible for managing the health care system, it was observed that the barriers between health and social policy actions are more pronounced. This compartmentalisation between sectors, at a time when health policies are influenced by a holistic World Health Organization (WHO) definition which states that health is "a complete state of mental and physical well being", is an important issue because it reduces the capability of systems to address the broader determinants of health.

In looking at different mechanisms used to develop health policy, the structures in each of the countries examined were allocated to one of three broad categories: multiple, dual or integrated systems.

## Multiple systems

This first category includes the systems found in Germany, Austria, and Italy. They are characterised by having both objective targets set at a federal level in line

with health targets recommended by the WHO Regional Office for Europe, while also developing different types of health programmes within regions.

In Germany for example in April 2003 seven health targets were set. Five related to specific conditions (diabetes, breast cancer, cardiovascular disease, chronic back pain and depression), one is relative to individual behaviour (tobacco consumption) while the other focused on a specific population target group (the under twenties). In Austria, health targets are set out in the federal government's triennial public health plan. In both countries the regions set their own health care policy.

In Italy meanwhile, the distribution of resources to the different regions is determined by a national funding plan which itself stems from health targets set out in a biennial national health care plan. For the 2002–2004 period, fifteen objectives and ten strategic projects were defined. Each objective was linked to actions on priority interventions, ensuring that these priorities were integrated into local and regional plans. Regional plans translate health targets into financial and organisational measures in the health care system, taking into account regional needs. Thus the link between the direction and priorities of the national plan and regional programmes is guaranteed by the central mechanism of budgetary allocation.

In all three countries the systems are characterised by an important division in the allocation of responsibilities and the great challenge of trying to reconcile these different roles within a common strategy. That is why it remains difficult to monitor changing trends in the mechanisms used to develop local health strategies.

### Dual systems

Finland, The Netherlands, Spain and Sweden all fall into the dual system category, where systems are characterised by a strong concern over inequality in access to and the quality of health services. Two characteristics of health policy have thus developed. The first focuses on health care services and: (1) defines principles of accessibility, (2) sets regulations linked to professional skills, and to the quality and risks associated with services, (3) includes health insurance benefits within the social security system, and (4) permits intervention by both the private and public sectors. The second specifically deals with prevention: communicable disease, prevention interventions targeted at children and adolescents, promotion both of nutritionally balanced diets and greater physical activity, improved health in the workplace, and measures to prevent pollution.[1] The approaches adopted in these four countries are enshrined in national legislation intended to define common objectives for health while being mindful of the need to respect human dignity and equality between individuals.

### Integrated systems

Within the devolved health care environment in the UK, the system found in England falls within this third category. The starting point for policy is to define public health priorities. For each priority health targets are developed and a group of recommendations relevant both to health care and prevention are set out. Here, different interventions for health are integrated into a global public policy that considers how health priorities can be implemented not only within the health care system but also how to address some of the broader determinants of health. Here the health care system is treated as one component of national health policy rather than being a stand alone structure; medical and social actions to meet the goals of national health policy can to some degree be integrated.

This system achieves a suitable level global consistency in approach and a decent level of completeness inasmuch as it defines choice criteria at both the regional and local level. It also introduces mechanisms for assessment, including the development of indicators to grade performance.

At this point in the analysis it can be observed that priorities, tools used at the national level and the degree of regional and local autonomy vary greatly from one country to the next. Two main issues meet: that of the health care system and that of the broader considerations of public health, with their implications for the entirety of health determinants. The intersection between these two issues is narrower in the 'multi-systems'. In contrast mechanisms used for integration deal with both issues in a recursive and associated manner. Nevertheless, despite the differences in these approaches, we observed a certain degree of convergence in the health policy decision-making process.

### Health policy: a combination of local and global factors

Vertical decentralisation can be defined as the dispersion of decision making powers within State bodies, and horizontal decentralisation as the dispersal of such power

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through non-governmental organisations (agencies or private companies). The power of any decision lies in the capacity to act upon potential choices. Decision making power thus contains several expression zones. The model developed by Paterson[2] can be used to draw out four components of the decision-making process. First, choice rests on how information is handled and analysed by experts: the expertise. Then on the basis of this expertise, the decision-maker makes a choice. This choice, before being implemented, must be financed, and occasionally subject to third party authorisation, for instance through a parliamentary vote or approval by an inter-ministry committee. This authorisation and financing constitutes the third component of the decision-making process. Execution is the final component as choices may be implemented where there is some margin for action.

While again there are important differences in political and administrative structures, again some convergence in the distribution of powers and responsibilities can be seen. This can be explained by the coming together of health issues within these countries. This common experience is due to the combination of central and local thinking on one hand, and the combining of individual and collective thinking on the other. Health issues are the subject of global and local articulation, where the latter sheds light on health services' daily reality for the former, which in turn provides some necessary hindsight for local delivery. There is a common will across countries to return strategic choice making to the local level, with the central level fulfilling a leadership role and providing support.

### Framed decentralisation

The English system is the most centralised. Some horizontal decentralisation in some activities has been introduced inasmuch as a direct negotiating mechanism between service providers and local purchasers serving between 100,000 and 200,000 people (Primary Care Trusts –PCTs) exists. This allows purchasers to buy services from both public and private service providers. Local PCTs negotiate directly with hospitals over service provision.

The Department of Health at the central level retains control over the power of expertise, authorisation, and financing as well as defining objectives and strategies. PCTs commission services on the basis of local needs taking into account national targets such as National Service Frameworks. Funding is distributed from the central level on the basis of weighted capitation. Local service providers are the subject of a system of performance assessment and evaluation by a central government body. There are financial incentives for trusts to perform well. This type of decentralisation can be called framed decentralisation because it allows more flexibility for action by stakeholders while framing this strongly by incentives and controls including the use of financial mechanisms.

The process of decentralisation in England has also evolved through allowing health care suppliers, including independent foundation trust hospitals to participate in defining their own strategies within the framework of national objectives and strategies. Even in the case of independent foundation trusts, the State as a last resort where performance is poor, retains the right to regain managerial responsibility.

### Coordinated decentralisation

Countries operating through a federal structure in theory should have the greatest degree of decentralisation. This also applies to countries with other governance structures such as Spain where the responsibility for the delivery of health care is a matter for the 17 Autonomous Communities and also in Sweden where county councils play a similar role. In Germany, Belgium, Spain and Sweden, at a central level a country-wide common programme is set out together with a list of recommendations.

In the most decentralised of countries, there is nevertheless a will to create national institutes of public health responsible for producing national epidemiological studies and disseminating information. This will deter duplication in studies undertaken at local and regional level, while reducing unnecessary expenditure on research and data collection.

Strongly decentralised countries seek to improve cohesion by tackling health and social inequalities between regions. This is why at a national level ministries of health set common principles, objectives and the general direction for policy. These items are set out for informative purposes so as to pinpoint the global needs of society. Setting a common aim and purpose for action is one of the first tools in coordinating individual activities. The priority in the public health care systems of all these countries is to ensure a level of homogeneity nationwide with a set of minimum entitlements for all.

It is then at the regional or local levels that actual health priorities are set, taking into account the common framework defined at the central level, but having latitude in how they define key activities and financing priorities. In certain autonomous regions, these regional programmes will be the subject of a regional parliamentary vote. Funds in decentralised countries can be collected at the central, regional and local level. In this way, regions have the possibility of financing their own programmes while central funding is thus concerned only with core national programmes. Eventually, the central level may define a set of indicators for evaluation and control, but this is just for information; the State holds no power over local initiatives.

We qualify this as coordinated decentralisation inasmuch as the regional and local levels determine the order in which they wish to resolve health care issues. The State then occupies two principal roles. The first is to provide support and supply information, scientific research, advice and coordination as well as act as a regulator guaranteeing equality and mobility nationwide. This can include regulation of professional bodies, as well as having measures of activity and quality control. In consequence, the State becomes a coordinator facilitating the emergence of the needs of public health from the promotion of scientific studies, taking into account local activities and their interactions within the global context. The State establishes a set of recommendations and guidelines giving the different actors the means to negotiate and make decisions. Ultimately, the State's position is that of a regional coordinator and regulator in the distribution of funds. A secondary role is in implementation. Indeed, the State may promote and intervene in the direct financing of integrated health plans for each priority area. The central level, positioned as a health policy actor working on national strategies for treatment and prevention, manages these plans.

## Conclusion

A number of conclusions can be drawn from this analysis. First, it must be emphasised that currently a strong ambiguity exists between the objectives of public health and the objectives of the health care system. This ambiguity is exacerbated by the ambiguities concerning the contents of these objectives. Moreover, there is sometimes confusion between objectives and strategies, where strategies are simply the objectives restated a little more precisely, but still with little visibility. In addition, recommendations on the ways of defining health objectives set out by international and European organisations often create the conditions for feedback on the differences between strictly national and international thinking. In some circumstances a strong disconnection between the practical consequences of these two approaches in a country may be reinforced by international seminars and discussion that highlight the divergence between national and international thinking.

A second conclusion concerns the compartmentalisation between health care treatment and preventive actions to address the broader social determinants of health. More attention is being paid to public health, with countries seeking to integrate broader health determinants within strategies. Nevertheless, the current mechanisms are much too fragmented, with funding received in separate ways, while the required skills and training of professionals differs. Moreover, the cross cutting impacts of the different fields are not very well known and difficult to identify. To this can be added the challenge of economic constraints faced by different sectors, such as employers, in respect of funds available for health promotion. This compounds the difficulties public administrative bodies have in negotiating with a variety of stakeholders over how to address these wider determinants of health. Consequently, countries both horizontally and vertically have decentralised the health decision-making process in order that discussions between stakeholders can now take place at the local rather than at the national level.

Thus in the quasi-market environment, the State is positioned as the guarantor of society's values and choices concerning inter and intra-generational solidarity and individual insurance. The third strong point is dependent on one condition: a governmental examination of citizens' social expectations and the linking of these different expectations within a common framework. It is open to question in a situation where the State has positioned itself as one of the actors, to what extent it can remain the guardian of social values given that it is already embedded in competing economic interests.

Today one of the most inferior components of health policy is the training of professionals and citizens on health issues. This work raises major questions because each step of health policy questions the motivation, interest, and commitment of actors.

*"Current mechanisms are too fragmented"*


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